STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS#72155, 70696, 70641. A revised copy of the deficiencies was sent to the facility on 5/5/14	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents. Based on observation, record review, and interview the facility failed to maintain a comfortable and sanitary interior of the facility on 3 of 3 halls for 3 of 4 days on site of the survey. Findings included: - Observation on 3/10/14 at approximately 10:00 A.M. until 5:00 P.M. and from 3/11/14 from 7:30 A.M. until approximately 12:00 P.M. revealed the following: On the North Hall a resident room had cracked flooring behind the toilet. On the South Hall a semiprivate room's towel bar lacked labeling. Another room on this hall had chipped paint, scuffed walls, the flooring was in poor condition, and rusted and uncovered toilet	F 253		4/11/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 253	Continued From page 1 bolts. In the dining room/common area of the secured unit there was peeling paint on the walls. On this hall there was a resident's bathroom with what appeared to be urine splatter on the wall next to the toilet. During the environmental tour and interview with administrative staff A and maintenance staff X on 3/13/14 at approximately 11:30 A.M. through 12:10 P.M. they acknowledged the areas of concern in the above observations. The maintenance checklist policy with a revision date of 1/1/2010, revealed maintenance performed checks on strategic equipment. The facility failed to ensure a clean and comfortable environment for the residents.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		4/11/14

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Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 44 residents. The sample included 13 residents. Based on observation, record review and interview the facility failed to develop accurate assessments for 3 residents (#19) with a foot ulcer, (#11) weight loss program and (#8) for nutrition.

Findings included:

- Resident #19's March 2014 Physician's Order Sheet (POS) recorded the resident had diagnosis that included: peripheral vascular disease, (PVD-thickening and narrowing of blood vessels in the arms and legs), and insulin dependent diabetes mellitus (IDDM- difficulty in regulating blood sugar levels).

The significant change Minimum Data Set (MDS) 3.0 assessment dated 12/20/2013 recorded the resident had a Brief Interview For Mental Status score of 15 which indicated the resident's cognition was intact. The MDS documented the

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resident required extensive assistance of two staff with transfers, bed mobility, dressing, toileting, and most activities of daily living (ADLs), had no unhealed pressure sores, no diabetic foot ulcers and had other open lesions on his/her foot beginning 9/13/13.

According to the Resident Assessment Instrument (RAI) users manual 3.0 revised May 2013, page M-33, classified other lesions, other than ulcers, rashes, and cuts by the following: Most typically skin ulcers developed as a result of diseases and conditions such as cancer.

The 12/20/13 significant change Care Area Assessment (CAA) for pressure ulcers recorded the residents diagnosis of PVD, noted the residents' visits to a hospital's wound care center, and the nurses notes recorded the resident was at risk for pressure sores, due to his/her refusal to get out of bed and refused showers.

Record review of a bruise investigation report dated 9/18/13 recorded the resident ran his/her electric wheelchair into a wall, knocked his/her feet off the foot rest and caused injury to his/her feet. This same investigative report documented a 2.5 centimeter (cm) long (L) by (x) 2 cm wide (W) purplish bruise to the resident's left heel.

The weekly non-pressure related skin wound record from 9/18/13 thru 3/6/14 documented the resident's left foot wound as a deep tissue injury (DTI). The weekly non-pressure related skin wound record further documented the progression of a blister-like lesion with covering skin to an area of black eschar (hardened scab-like area of dead skin) to a 3.5 centimeter (cm) x 2.5 cm open area with serous (yellowish

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discharge) on the residents' inner left heel.

According to the Resident Assessment Instrument (RAI) users manual revised May 2013, section MO300G, pages M-19, M-20, classified unstageable pressure ulcers related to suspected deep tissue injury by the following: Purple or maroon colored area of intact skin due to damage of underlying soft tissue. The area may be preceeded by tissue that was painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

The resident's care plan (revised 12/31/13) recorded the resident had a left heel deep tissue injury and directed staff to provide treatments, and maintain pressure reduction measures, but lacked documentation of a descriptive account of the resident's left heel wound treatments.

Observation on 3/11/14 at 10:30 A.M., during the left heel wound dressing change by licensed nurse H revealed the resident had an approximately 2 cm (L) x 1.5 cm (W) x 0.3 cm (D) open area over a bony prominence, his/her left inner heel. Staff treated the wound per the physicians order.

Interview on 3/11/14 at 9:00 A.M. the resident indicated he/she recalled the accident with his/her wheelchair and stated the skin tears and bruises on his/her toes were healed but that he/she had a wound on his/her left heel (not caused by the wheelchair), hurt at times, and developed because of his/her diabetes and from lying in bed.

Interview on 3/11/14 at 9:00 A.M. with administrative licensed nurse D stated the resident had a diabetic ulcer on his/her left heel

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that developed in part when he/she ran his/her electric wheelchair into a pole (pillar) and skinned his/her toes and caused a deep tissue injury (DTI) to his/her heel.

Interview on 3/11/14 at 10:30 A.M. licensed nurse H stated he/she was unsure how the resident developed the ulcerated area to his/her left heel. He/she said he/she treated the wound since last year and it started as a blister that popped and then developed a hard black scab, that came off.

Interview on 3/13/14 at 12:10 P.M. administrative licensed nurse F stated staff recorded the resident's left heel wound on the MDS as an other open lesion and not documented on the MDS as a pressure ulcer or diabetic ulcer because it was characterized as a deep tissue wound.

Interview on 3/13/14 at 12:10 P.M. consultant BB stated the deep tissue injury on the MDS referred only to pressure sores.

The facility MDS assessment policy revised 2/27/14 recorded, each resident would receive a comprehensive assessment of his/her needs based on a uniform data set utilizing the RAI process.

The facility failed to accurately assess the resident's left foot wound to indicate an ulcerated area developed from a deep tissue injury.

- The quarterly Minimum Data Set (MDS) dated 12/11/13 for resident #11 revealed a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). The resident required

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supervision with set help only with eating. The resident lacked swallowing disorders, and weighed 276 pounds. The resident was on a physician prescribed weight loss program with no weight loss or gain and was not on a mechanical altered or therapeutic diet. The resident received a diuretic (a medication that removes water from the body) medication.

The Care Area Assessment dated 7/25/13 for nutritional status revealed the resident had a decline in condition, received hospice services, and required assistance with feeding.

The signed Physician's Order Sheet (POS) dated 1/30/14 revealed orders for a regular diet with thin liquids, V8 juice with lunch and dinner, Mighty Shake with breakfast daily, and Lasix (a water pill) 40 milligrams (mg) by mouth (PO) and 20 mg Lasix tablet to equal 60 mg, twice daily for diuresis (remove water from the body).

The signed POS dated 1/30/14 lacked orders for a physician prescribed weight loss program.

Observation on 3/12/14 at 11:23 A.M. revealed the resident received a chocolate brownie cake with frosting, steamed red new potatoes, roast beef with brown gravy, a dinner roll, and whole baby carrots in a divided plate. The resident also received water, chocolate milk and tomato juice. Licensed nurse I identified the resident's food placement by clock position. The resident refused to eat the carrots, potatoes, and chocolate milk. The resident ate all of the brownie, 3/4 of the dinner roll, took 4 bites of the roast beef, and drank all of the tomato juice.

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Interview on 3/13/14 at 4:00 P.M. with administrative nursing staff F stated the resident received Lasix for diuresis and the Resident Assessment Instrument (RAI) indicated for staff to code the MDS as a physician prescribed weight loss regimen.

The revised policy and procedure dated 2/17/14 titled MDS revealed each resident shall receive a comprehensive assessment of her/his needs based on a uniform data set utilizing the RAI process.

The facility failed to accurately record this resident's weight loss program on the MDS.

- Review of the quarterly Minimum Data Set (MDS) 3.0 dated 11/8/13 for resident #8 revealed a Brief Interview for mental status (BIMS) score of 15 which indicated no cognitive impairment. The resident weighed 315 pounds. Weight gain was expected because the resident was on a physician prescribed weight gain regimen.

Review of the annual MDS 3.0 dated 2/7/14 revealed a BIMS score of 11 indicating moderate cognitive impairment. The resident weighed 314 pounds. Weight gain was expected because the resident was on a physician prescribed weight gain regimen.

Review of the care plan dated 2/18/14 for nutritional risk revealed the staff were to provide diet as ordered, monitor weight, provide medication and supplements as ordered, assist with meals as needed, and obtain a dental consult as needed.

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Review of the dietician assessment dated 11/7/13 recorded the resident weight of 315 pounds and the resident was to receive a low concentrated sweet diet and he/she refused to follow any diet.

Review of the physician's order dated 3/1/14 the resident was to receive a regular diet with low concentrated sweets and a protein snack at bedtime.

Review of the weight list provided by administrative staff D revealed the resident weighed 317 pounds on 10/13, 315 pounds on 11/13, 319 pounds on 12/13, 314 pounds on 1/14, 315 pounds on 2/14 and 317 pounds on 3/14

Observation on 3/11/14 at 8:33 A.M. the staff provided a room tray of 2 biscuits and gravy, 2 4 ounces of juice, 8 ounces of cream of wheat and he/she had personal soft drinks at the bedside.

Observation on 3/11/14 at 8:45 A.M. the resident consumed 100 percent of the breakfast provided.

Interview on 3/12/14 at 4:54 P.M. licensed staff L stated the resident ate in his/her room and consumed all the meals provided.

Interview on 3/13/14 at 2:02 P.M. licensed staff H stated the resident was noncompliant with his/her diet and received a bedtime snack.

Interview on 3/12/14 at 11:13 A.M. consultant

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F 278	Continued From page 9 staff DD stated he/she reviewed residents at nutritional risk. The director of nurses, assistant director of nurses, MDS coordinator and dietary manager attended the weekly wound and weight meeting to discuss the health status of the residents. The director of nurses provides the weekly weight list. The MDS coordinator updated the careplans. Interview on 3/13/14 at 4:28 P.M. MDS coordinator F stated the previous dietary manager had completed section K of the November 2013 MDS and was no longer with the facility. The facility failed to accurately assess and code the MDS regarding weight loss.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		4/11/14

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F 279	Continued From page 10 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents. The sample included 13 residents. Based on observation, record review and interview the facility failed to develop individualized, comprehensive care plans that accurately reflected residents' status affecting 5 residents for the following: behavior and emotional status (#2), nutrition (#2, #8, #45, #17), pain (#8), physical restraints (#17), unnecessary medications (#8, #17), and urinary catheters (#11). Findings included: - The quarterly Minimum Data Set (MDS) dated 12/11/13 for resident #11 revealed a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). The resident required extensive assistance of two persons with bed mobility, transfers, dressing, bathing, was total dependence of 2 persons with locomotion on/off the unit,he/she required supervision with eating, required limited assistance of 2+persons with toilet use, and limited assistance of one person with personal hygiene. The resident had an indwelling catheter and a diagnosis of obstructive uropathy(any disease or other change in	F 279		

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the urinary tract).

The CAA dated 7/25/13 for indwelling catheter revealed the resident had a Foley catheter placed in the hospital related to urinary retention. Nursing staff would maintain the Foley catheter until change of order by a Urologist (a physician who specialized in the practice of urology) and primary physician.

The Care Area Assessment (CAA) dated 7/25/13 for indwelling catheter revealed the resident had a Foley catheter placed at the hospital and continued in place related to urinary retention; to be maintained until change of order by the urologist or primary physician.

The care plan dated 1/23/14 for urinary catheter (a tube in the bladder to drain urine into a closed bag) use revealed nursing staff would complete a catheter assessment quarterly, change the catheter as needed, provide catheter care to prevent a urinary tract infection (an infection of the bladder), observe for obstruction, urethral erosion (redness at the urethral opening), bladder spasm (bladder cramps), hematuria (blood in the urine), leakage, pain/discomfort, place the catheter in a privacy bag at all times, suprapubic placement (urinary bladder catheter inserted through the skin), social services would schedule a follow-up appointment in one month, monitor site every shift for drainage at suprapubic catheter site, report infections to the physician, record output and report no urinary output, apply moist warm compress for four 4 days, suprapubic catheter care daily and as needed (PRN), abdominal sutures removed at the urology appointment, nursing staff would provide medication/treatments as ordered to the

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suprapubic site, change catheter as ordered, and empty the catheter bag every shift and as needed. Hospice to provide placement of a suprapubic catheter- appointment to be determined, nothing by mouth (NPO) after midnight January 12, 2014 for suprapubic catheter placement, Foley catheter replacement at the hospital as needed, antibiotics as ordered for UTI, indwelling urinary catheter to remain in place unless it fell out or was blocked, flush the catheter per orders, flush catheter per clarification order, Caude catheter (catheter with a curved tip for easier placement) 14 french/5 millimeter balloon, and the resident may require repeated hospital trips for Foley catheter placement due to sedimentation or clogging. Nursing staff would change the suprapubic catheter as ordered and flush as ordered.

The urinary catheter care plan dated 1/23/14 lacked documentation the care plan was individualized and continued to reflect the care of an indwelling Foley catheter when the resident had a suprapubic catheter.

Observation on 3/12/14 at 7:19 A.M. revealed the resident laid in bed on an air mattress with the head and foot of the bed elevated. A Foley catheter bag was in a dignity bag which hung on the side of the bed.

Interview on 3/13/14 at 12:21 P.M. with licensed nursing staff H stated the MDS Coordinator was responsible for the development of the care plans.

Interview on 3/13/14 at 3:12 P.M. with licensed nursing staff I stated the MDS Coordinator was responsible for the development of care plans.

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F 279	Continued From page 13 Interview on 3/13/14 at 4:23 P.M. with administrative nursing staff D stated nursing staff developed the care plans when new orders arrived and care plan updates were discussed at daily meetings. It were her/his expectation the care plan provided individualized needs of the resident. The reviewed care plan policy dated 2/27/14 titled Care Plan revealed the facility must develop a comprehensive care plan for each resident which included measurable objectives and time tables to meet the resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. The facility failed to provide a comprehensive care plan for this resident for urinary catheter. - The quarterly Minimum Data Set 3.0 (MDS) dated 2/17/14 for resident #45 revealed a Brief Interview for Mental Status score of 14, indicating no cognitive impairment. The resident required set up assistance with bed mobility, transfer, walking in his/her room and corridor, locomotion on and off the unit, and dressing. The 8/30/13 Care Area Assessment (CAA) regarding Activities of Daily Living (ADLs) revealed the resident was at risk for a decline in ADL function due to a change in his/her environment and behavioral complications. The resident refused to perform ADLs at times. Staff	F 279		

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encouraged and monitored the resident for the completion of ADLs.

The 8/21/13 care plan regarding nutrition, with a revision date of 1/29/14, revealed the resident was at risk for a nutritional decline due to dementia (progressive mental disorder characterized by failing memory and confusion) and decreased appetite. The resident received a regular diet. Staff monitored the resident's weights as indicated. Staff honored the resident's food preferences as applicable.

The 9/30/13 care plan regarding weight loss, with a revision date of 10/30/13, revealed the resident had a history of weight loss and was on the facility's weekly weight meeting agenda. The dietitian performed a nutritional assessment. Staff reviewed the resident's likes and dislikes. Staff ordered appropriate labs including total protein, pre-albumin, albumin, and blood glucose.

The care plan lacked individualization regarding the frequency that staff monitored weekly weights, the frequency of laboratory monitoring, the frequency of the nutritional assessment, and the resident's food preferences.

Observation on 3/12/14 at 7:13 A.M. the resident sat in a chair in the dining room of the facility and ate breakfast independently.

Interview on 3/13/14 at 9:34 A.M. with administrative nursing staff F revealed the MDS coordinator developed the care plans.

Interview on 3/13/14 at 10:50 A.M. with licensed nursing staff J revealed the nurses reviewed the care plan but the MDS coordinator developed the

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care plans. Staff J expected the care plan to be individualized for each resident.

Interview on 3/13/14 at 2:42 P.M. with licensed nursing staff K the MDS coordinator developed the care plans. The MDS coordinator attended the morning meeting, and from the 24 hour report logs developed the care plans. Staff K expected the care plan to be individualized for the resident.

Interview on 3/13/14 at 3:45 P.M. with administrative nursing staff D revealed he/she expected the care plan to be individualized for the resident.

The care plan policy with a revision date of 2/27/14, provided by the facility revealed the facility developed a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs that were identified from the comprehensive assessment.

The facility failed to develop an individualized, comprehensive care plan regarding nutrition for this resident with a history of weight loss.

- Review of the quarterly Minimum Data Set (MDS) 3.0 for resident #2 dated 2/6/14 revealed the Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The resident had disorganized thinking behavior that fluctuated, unclear speech but could understand others, and had a vision impairment that required glasses. The resident was independent with

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F 279	Continued From page 16 eating after set up by staff, required extensive assist of 2 staff for bed mobility, dressing, and personal hygiene. Review of the care plan dated 2/12/14 for self care deficit related to eating revealed the staff were to provide supplements as indicated, the care plan for nutritional risk revealed the staff were to provide diet as ordered, monitor weight, honor food preferences as applicable, supplements as ordered for weight management,the care plan for history of weight loss revealed the staff were to notify the physician, notify family, and supplement as ordered. The care plan lacked individualization for the resident for example: the type of diet, type of supplement for weight monitoring, frequency of weight monitoring, and food preferences. Observation on 3/12/14 at 9:15 A.M. direct care staff Q and R at bedside to assist with a bath. Interview on 3/13/14 at 12:10 P.M. administrative licensed staff F stated the resident care plans were developed immediately using a variety of tools, in effect, resident and staff interview, the 24 hour report sheet, and physician orders and assessment data. Interview on 3/13/14 at 12:10 P.M. administrative licensed staff D stated staff attempt to develop care plans that were individualized for the resident.	F 279		

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The care plan policy provided by the facility revised 2/14/14 revealed the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetable to meet the resident medical nursing and mental and psychosocial needs.

The facility failed to include measurable objectives and individualized care for this resident for the type of diet, type of supplement for weight monitoring, frequency of weight monitoring, and food preferences.in the resident's care plan.

- Review of the annual Minimum Data Set (MDS) 3.0 dated 2/7/14 for resident #8 revealed a Brief Interview for mental status (BIMS) score of 11 indicating moderate cognitive impairment. The resident required supervision of one staff for bed mobility, transfers, walking in the room and corridor, eating, toileting, and personal hygiene. The resident required physical assistance with bathing, was not steady on his/her feet but was able to steady without assistance for sit to stand, moving on and off the toilet, transfers, and had impairment with upper and lower extremities. The resident was on a bladder program and was frequently incontinent, was not on a bowel program and was occasionally incontinent of bowel.The resident received scheduled pain medication and rated his/her pain at a "7" on a scale of 1 to 10, frequently but did not receive as needed pain medication. The resident had one non injury fall and had shortness of breath. The resident was on a therapeutic diet, had no natural teeth and had loose or broken dentures. The resident was not at risk for a pressure ulcer. the resident received injectable insulin, antidepressant, anticoagulant, and diuretic

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medications on 7 of 7 days. The resident received oxygen therapy.

Review of the CAA dated 2/7/14 for cognitive loss revealed the resident did not make rational decisions and required assistance.

Review of the care plan dated 2/18/14 for inappropriate behaviors revealed staff were to provide medications as ordered.

Review of the care plan dated 2/18/14 for dental pain revealed staff were to provide a dental adhesive of choice and provide a diet consistency the resident was able to chew without difficulty.

Review of the care plan dated 2/18/14 for risk of skin breakdown revealed the staff were to provide treatments as ordered.

Review of the care plan dated 2/18/14 for urinary incontinence revealed the staff were to provide absorbent products as ordered, and administer medications as ordered.

The care plans lacked individualization for the resident for example: what staff sprecifically should do for behaviors. incontinence and dental care and to prevent skin breakdown.

Observation on 3/11/14 at 2:40 P.M. the resident sat in his/her wheelchair in the activity room and engaged in group activity with 4 other residents. A pressure cushion was in the wheelchair.

Interview on 3/13/14 at 2:02 P.M. licensed staff H stated the care plan did not specify the frequency for the resident weights.

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Interview on 3/13/14 at 12:10 P.M. administrative licensed staff F stated the resident care plans were developed immediately using a variety of tools, in effect, resident and staff interview, the 24 hour report sheet, and physician orders and assessment data.

Interview on 3/13/14 at 12:10 P.M. administrative licensed staff D stated staff attempt to develop care plans that were individualized for the resident.

The care plan policy provided by the facility revised 2/14/14 revealed the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetable to meet the resident medical nursing and mental and psychosocial needs.

The facility failed to include measurable objectives and individualized the care for this resident, specific diet and supplements the resident received, food preferences and treatments.

- The quarterly Minimum Data Set (MDS) 3.0 dated 3/1/14 for resident #17 revealed the resident had no discernable consciousness and was totally dependent of 2 staff for bed mobility, transfers, dressing, toileting, personal hygiene. The resident was totally dependent on 1 staff for receiving nutrition through a feeding pump to a percutanious endoscopic gastrostomy (PEG) tube, (a tube inserted into the stomach to provide nutrition). The artificial feeding was more than 51% of total intake and received more than 501

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F 279	Continued From page 20 cc per day. Review of the annual Care Area Assessment (CAA) dated 7/2/13 for nutrition/activities of daily living revealed the resident received nothing by mouth, he/she had a PEG tube and received Glucerna 1.0 at 60 ml per hour continuously through the PEG tube. Review of the CAA dated 7/2/13 for functional status revealed the resident was totally dependent of two staff for all bed mobility, transfers, dressing, toileting, personal hygiene, bathing and total assist of one staff for locomotion on and off unit and feeding. Review of the care plan dated 2/14/14 for PEG tube feedings revealed the staff were to do laboratory tests as ordered, feeding tube as ordered, administer medications and flushes as ordered via the PEG tube, change tube as ordered, and tube flush as ordered. Review of the care plan dated 2/14/14 for nutritional risk revealed the staff were to provide diet as ordered via PEG tube, maintain tube feedings as ordered, and perform laboratory tests as ordered. The care plans lacked individualization for the resident for example: artificial nutrition and the amount of water to flush the PEG tube. Observation on 3/11/14 at 2:30 P.M. the resident was in bed, artificial nutrition noted in bag at bedside being infused per feeding pump at 55	F 279		

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F 279	Continued From page 21 cc/hr. Interview on 3/13/14 at 12:10 P.M. administrative licensed staff F stated the resident care plans were developed immediately using a variety of tools, in effect, resident and staff interview, the 24 hour report sheet, physician orders, and assessment data. Interview on 3/13/14 at 12:10 P.M. administrative licensed staff D stated staff attempt to develop care plans that were individualized for the resident. The care plan policy provided by the facility revised 2/14/14 revealed the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetable to meet the resident medical nursing and mental and psychosocial needs. The facility failed to include measurable objectives and individualized care for this resident for artificial nutrition and the amount of water to flush the PEG tube.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		4/11/14

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interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 44 residents. The sample included 13 residents. Based on observation, record review, and interviews, the facility failed to revise the comprehensive care plan to reflect changes related the use of palm guards (used to keep the hand from closing completely) and range of motion exercises for 1 of 1 (#37) residents sampled for activities of daily living.

Findings included:

- Resident #37's Minimum Data Set (MDS) 3.0 assessment dated 1/1/14, documented the resident had short and long term memory impairment, severely impaired decision making skills, required extensive assistance of one to two staff with most activities of daily living (ADLs), including personal hygiene and bathing, and had frequent bowel and bladder incontinence.

The resident's care plan (revised 1/30/14) directed staff to assist with ADLs that included dressing, repositioning, toileting, perineal care

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and showers.

The care plan documented a discontinued physician's order dated 10/10/13 for the resident to wear hand palm guards, at all times, and they may be off for bathing, hand hygiene, and meals.

The care plan lacked documentation of the 3/10/14 revised physician's order to provide passive range of motion (ROM) exercises to the resident's hands at bedtime and then apply the palm guards and remove them at 6 A.M. The care plan also lacked documentation the resident received fingernail care, lotion application, or other hand hygiene.

Observations on 3/11/14 at 8:00 A.M., 3/12/14 at 7:30 A.M., 11:30 A.M., and 4:44 P.M. revealed the resident unable to fully open his/her hands (in an open fist position) and with long fingernails.

Interview on 3/13/14 at 7:35 A.M. the resident stated he/she did not wear palm-guards (laying on over bed table) because "They are funny looking things," and "I do not need them."

Interview on 3/13/14 at 1:30 P.M. administrative licensed nurse F stated the resident's care plans were updated immediately (within 24 hours) to reflect any changes or new physician's orders.

The facility's care plan policy (revised 2/27/2014) lacked documentation to reflect timely revisions to resident care plans.

The facility failed to revise the care plan to reflect individual use of palm guards, and the physician's order for range of motion exercises for this cognitively impaired resident.

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		4/11/14

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 44 residents. The sample included 13 residents of which 4 were reviewed for pressure ulcers. Based on observation, record review, and interviews the facility failed to prevent the reoccurring development of an avoidable pressure ulcers and failed to provide interventions as planned for 1 (#11) resident of the sample.

Findings included:

- The quarterly Minimum Data Set dated 12/11/13 for resident #11 revealed a Brief Interview for Mental Status score of 14 (cognitively intact). The resident required extensive assistance of two plus (2+) persons with bed mobility, transfers, dressing, bathing, required total dependence of 2+ persons with locomotion on/off the unit, required supervision with set-up with eating, required limited assistance with 2+ persons with toilet use, and limited assistance of one person with personal hygiene. The resident had functional limitation in range of motion (ROM) with both lower

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extremities. The resident had an indwelling catheter. The resident was at risk for developing a pressure ulcer, did not have one or more unhealed pressure ulcer, had moisture associated skin damage (MASD). The skin treatment consisted of a pressure reducing device for the bed and chair and application of ointments/medications other than to the feet.

The Care Area Assessment dated 7/25/13 for pressure ulcer revealed the resident did not have a pressure ulcer but had a right lower diabetic ulcer staff treated and she/he received hospice services.

The care plan dated 7/24/13 for at risk for skin breakdown related to nutritional status, obesity, chronic lower extremity (LE) wounds, edema, cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling), venous insufficiency (a failure of the valves of the veins to function and may produce edema), and decreased mobility revealed a Braden (a screening tool used to measure a resident's risk of developing a pressure ulcer) screen and nutritional assessment would be completed on admission, quarterly, and change in status.

Nursing staff would document nutritional intake and assist with meals, required two assist with repositioning, offer/encourage fluids throughout the day, provide supplements and obtain appropriate labs as indicated, document change in skin color, turgor, etcetera (etc) and elevate the residents legs as allowed. The resident used a low air loss bariatric (obese) mattress.

The care plan dated 3/5/14 for at risk for skin

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breakdown related to obesity, diabetes (when the body cannot use glucose, there was not enough insulin made or the body cannot respond to the insulin), and fragile skin revealed nursing staff would ensure all body folds were cleansed and dried on bath/shower days and report any redness or breakdown, provide treatments to bilateral lower extremities (BLE), skin treatment three times (3 x) daily, elevate BLEs on pillows and change pillow cases every shift, place disposable chux (protective pad) over the pillows which were under the bilateral lower extremities and changed every shift, treatment to coccyx (tail bone) skin tear, clarification order for treatment to the buttocks as ordered, report any red areas to the nurse immediately, keep linen wrinkle free as possible, assure resident was free of body waste, keep linen clean and dry as possible, receive hospice services as indicated, monitor acute changes as they arose, and provide treatments as ordered.

The lab dated 12/20/13 revealed the albumin level (a blood test used to measure the amount of protein in the blood and was used in part to determine a person's nutritional status) was low at 3.2 grams per deciliter (g/dl) with the normal range of 3.5 to 5.5 g/dl.

The nurse's note dated 2/18/14 at 8:10 A.M. revealed the resident had a skin tear on the coccyx 1.0 centimeter (cm) by (x) 0.1 cm, hospice, the physician, and family were notified, and nursing staff would apply Calazime (a zinc barrier cream) to the coccyx (tail bone) every shift.

The Braden Assessment dated 3/11/14 revealed a total score of 11. A score of 10 to (-) 12

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indicated high risk for pressure ulcers.

The Nonpressure Skin Condition Record dated 1/13/14 revealed the resident had an abrasion 3.0 cm x 1.0 cm on the coccyx. On 1/15/14 the open area measured 0.5 cm x 0.1 cm, and healed on 1/22/14.

The signed Telephone Order (TO) dated 1/15/14 revealed orders to discontinue the treatment to the resident's coccyx.

The signed TO dated 3/5/14 revealed clarification orders to discontinue all other treatments to the buttocks/coccyx and physician orders to cleanse coccyx area with wound cleanser, apply skin prep and then apply Calazime every shift.

The Weekly Skin Integrity Review dated 3/12/14 revealed the resident had venous stasis (stoppage of the normal flow of blood caused by venous congestion) areas on the BLE and lacked documentation of the pea sized open area on the coccyx.

The Nurse Tech Information Kardex (paper to identify care the resident required) for certified nursing aides (CNA) revealed the resident was incontinent of bowel and used a bedpan for bowel movement (BM) at times, had a suprapubic catheter (urinary bladder catheter inserted through the skin) and staff were to empty the catheter bag every shift and as needed, to reposition the resident every 2 hours and as needed, the resident had a chair cushion and bariatric low air mattress bed, and received treatment to BLE.

Observation on 3/12/14 at 8:21 A.M. revealed

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consultant staff KK provided skin treatment to the resident's coccyx and BLE and administrative nursing staff E assisted. Consultant staff KK cleansed the resident's coccyx with wound cleanser, applied skin prep and Calazime ointment. At that time consultant staff stated the open area was a denuded area (removal of a protecting layer or covering through surgery, pathological change, or trauma) probably caused by moisture.

According to the National Pressure Ulcer Advisory Panel Quick Reference Guide for Pressure Ulcer Prevention listed excessive skin moisture was a risk factor for the development of pressure ulcers.

Observation on 3/12/14 at 10:00 A.M. revealed the resident sat on a bariatric air mattress bed with the head of bed and feet elevated. At 10:30 A.M., 11:03 A.M., 11: 30 A.M., 12:00 P.M. and 12:30 P.M. the resident remained in the same position. At 12:35 P.M. a skin check was requested.

Observation on 3/12/14 at 12:45 P.M. (2 hours and 45 minutes without a change in position) administrative nursing staff E and licensed nursing staff I turned the resident onto her/his left side to check the resident's coccyx. The coccyx area had dark pink Calazime ointment and was unable to assesses if the resident's skin area was red.

Record review on 3/13/14 at 3:00 P.M. lacked documentation regarding the proper setting for the resident's air mattress.

Observation on 3/13/14 at 3:23 P.M. revealed the

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air mattress setting at a 10 minute cycle and the pressure range with 4 lights lit.

Interview on 3/13/14 at 3:15 P.M. with licensed nursing staff I stated she/he did not know what the air mattress setting was set on. She/he stated the facility did not have the manufacturers guidelines for the use of the air mattress and the hospice nurse checked the resident's weight and adjusted the air mattress to the resident's weight.

Consultant staff LL stated on 3/18/14 at 3:14 P.M. each light on the air mattress control for pressure was in relation to 81 pounds of weight. When the air mattress was delivered, the driver asked for the resident's weight, if not already reported and set the air mattress to the weight of the resident. The facility was also instructed they could adjust the pressure setting if it was too hard or too soft for the resident. With 4 lights lit it was comparable to the resident's weight of 324 pounds.

According to the clinical record the resident weighed 274.5 pounds on 3/2/14.

Observation on 3/13/14 at 4:30 P.M. with administrative nursing staff E as she/he stated she/he checked the resident's coccyx area and did not see an open area. Staff turned the resident onto her/his left side, wiped off a small area of the Calazime ointment from the coccyx area and observed the open area. At that time administrative nursing staff E stated she/he was not aware of the open area.

Interview on 3/12/14 at 5:50 P.M. the resident stated nursing staff encouraged her/him to move around in bed and demonstrated this by sliding

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her/his bottom area back and forth on the sheet over the air mattress.

According to Advances in Skin Care by Lippincott, Williams, and Wilkins friction and shear were mechanical forces contributing to pressure ulcer formation. The tissue injury resulting from these forces may look like a superficial skin insult. Shear was a "mechanical force that acted on an area of skin in a direction parallel to the body's surface. Shear was affected by the amount of pressure exerted, and the extent to which the body made contact with the support surface. Friction was the "mechanical force exerted when skin was dragged across a coarse surface such as bed linens." A skin insult caused by friction looked like an abrasion or superficial laceration. Fiction then combined with shearing forces and the ultimate outcome may be a pressure ulcer. Tissues subjected to friction were more susceptible to pressure ulcer damage.

Interview on 3/12/14 at 12:35 P.M. with licensed nursing staff H stated she/he asked the resident if she/he needed repositioning and the resident refused.

Interview on 3/12/14 at 12:55 P.M. with licensed nursing staff I stated staff repositioned the resident every 2 hours and she/he was able to move her/his hips from side to side without assistance.

Interview on 3/13/14 at 11:15 A.M. with direct care staff S stated nursing staff repositioned the resident from side to side every 2 hours.

Interview on 3/13/14 at 12:21 P.M. with licensed nursing staff H stated nursing staff repositioned

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the resident onto her/his side with a pillow if the resident allowed, and the resident was able to shift her/himself.

Interview on 3/13/14 at 1:15 P.M. with administrative nursing staff E stated nursing staff repositioned the resident every 2 hours when staff checked the resident for bowel incontinence and application of treatment.

Interview on 3/13/14 at 1:38 P.M. with direct care staff P stated the resident was not repositioned as she/he could reposition her/himself. At 3:37 P.M. direct care staff P also stated she/he informed the charge nurse if she/he noted any skin issues.

Interview on 3/13/14 at 4:27 P.M. with administrative nursing staff D stated nursing staff offered repositioning to the resident and at times she/he refused. The resident was able to reposition her/himself by rocking from side to side. The resident was off loaded from her/his coccyx by rolling up something small and placing it behind the resident. The resident called nursing staff when she/he wanted the roll removed. The charge nurse or unit manager performed weekly skin checks. The Certified Nurse Aide checked the resident for repositioning and incontinency every 2 hours and upon her/his request.

The revised policy and procedure dated 9/01/11 titled Positioning revealed some residents were unable to properly position themselves in bed and/or chairs. It was extremely important resident's positions were changed at least every 2 hours to assist in preventing skin breakdown and contractures as well as promoting comfort and

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F 314	Continued From page 32 safety. The revised policy and procedure dated 01/01/11 titled Assessment and Documentation of Wounds revealed accurate assessment and documentation of wounds and wound status was vitally important in management of wounds regardless of the etiology. The facility failed to assess, document, provide support surfaces as planned, and reposition this dependent resident as planned who developed an open area on the coccyx and had a history of open areas to the coccyx.	F 314		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to ensure a functioning call light system for 15 beds and 2 bathrooms on 3 of 3 halls. Findings included: - Observation on 3/11/14 from 7:30 A.M. until 8:30 A.M. revealed the following:	F 463		4/11/14

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On the secured unit the call system did not light on the panel and/or did not activate for 5 beds.

On the North Hall 2 resident bathrooms lacked a pull cord to activate the call light.

On the South Hall the call system did not light on the panel and/or did not activate for 10 beds.

Review of the work history report provided by the facility, the nurse call system test was conducted monthly but lacked evidence of what portion of the system, or which call lights were checked.

Interview on 3/11/13 at 7:50 A.M. with licensed nursing staff M revealed he/she expected all call lights to be in working order for the residents.

Interview on 3/11/14 at 8:30 A.M. with maintenance staff X revealed the maintenance director did not check the call lights for functionality. Staff X reported the facility relied on the residents and staff to report any problems regarding the call system. Staff X reported there were no logs kept for the functioning of the call system.

Interview on 3/11/14 at 4:58 P.M. with administrative staff A revealed the maintenance department checked the call lights monthly.

Interview on 3/13/14 at 10:35 A.M. with direct care staff T revealed he/she expected the call lights to be functioning at all times for the residents.

The policy regarding communications systems and maintenance inspection testing for safety provided by the facility, with a revision date of

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F 463	Continued From page 34 1/1/09, revealed communications systems and components were properly maintained to function reliably and ensure operator safety, including the nurse's call system. The facility failed to ensure the residents had a way to alert staff of their needs by maintaining a functioning call light system.	F 463		